

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 09201

9211

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Howard County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural ELlicott City 16yn.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Ellicott City x</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Folly Quarters Road</u>		d. STREET ADDRESS <u>Folly Quarters Road</u>	
3. NAME OF DECEASED (Type or print) <u>Anthony</u> First Middle Last		4. DATE OF DEATH <u>Aug.</u> Month Day Year <u>31</u> <u>19 61</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-13-15</u> 9. AGE (In years last birthday) <u>46</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lay brother</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SEMINARY</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>2</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no. or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>FR. RUFUS WIGELINSKI</u> Address <u>ELlicott City, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> (b) <u>—</u> (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Thomas F. Herbert</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Thomas F. Herbert, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>9/1/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>M. F. SADOWSKI & SONS, 1808 EASTERN AVENUE</u>		22d. LOCATION (City, town, or county) (State) <u>Auburn, N.Y.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>M. F. SADOWSKI & SONS, 1808 EASTERN AVENUE</u>		24a. REC'D BY REGISTRAR <u>SEP 5 '61</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kneale</u>	

NO. 1000

DECEASED
NAME
AGE
SEX
RACE
DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
MANNER OF DEATH

[Faint, illegible handwritten text in the main body of the form, likely containing patient details and medical history.]

9212

CERTIFICATE OF DEATH

Reg. Dist. No.

09202

1. PLACE OF DEATH a. COUNTY Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural* Florence		c. LENGTH OF STAY IN 1b Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RFD # 2, Woodbine		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Vernon Middle E. Last Duvall		4. DATE OF DEATH Month August Day 29 Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 21, 1890
9. AGE (In years last birthday) 71 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter	11. BIRTHPLACE (State or foreign country) Florence, Md.
100. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		100b. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Oath Duvall		14. MOTHER'S MAIDEN NAME Emma Hobbs	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-09-7254	
17. INFORMANT Forest B. Duvall, Ellicott City, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion with Myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, generalized (c) Old rheumatic mitral regurgitation since childhood PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Old rheumatic mitral regurgitation since childhood			
INTERVAL BETWEEN ONSET AND DEATH New sec conds.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 10 , 19 61 , to Aug 29 , 19 61 that I last saw the deceased alive on Aug 28 , 19 61 , and that death occurred at 5:30A M. from the causes and on the date stated above.			
ACTUAL SIGNATURE G. F. Meadors		DATE SIGNED 8/29/61	
PHYSICIAN'S NAME (Type) G. F. MEADORS, M.D.		Address (Street, city or town, state) Main Street	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/31/61	
22c. NAME OF CEMETERY OR CREMATORY Jennings Chapel		22d. LOCATION (City, town, or county) (State) Florence, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Chas. L. Molenbuth		24a. REC'D BY REGISTRAR DATE AUG 31 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1953

(M)

RECEIVED
FEB 1 1953
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.

MEMORANDUM

TO: DIRECTOR, AID

FROM: [illegible]

SUBJECT: [illegible]

1. [illegible]

2. [illegible]

3. [illegible]

4. [illegible]

5. [illegible]

6. [illegible]

7. [illegible]

8. [illegible]

9. [illegible]

10. [illegible]

11. [illegible]

12. [illegible]

13. [illegible]

14. [illegible]

15. [illegible]

16. [illegible]

17. [illegible]

18. [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9213

CERTIFICATE OF DEATH

09203

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North Laurel				c. LENGTH OF STAY in 1b 2 yrs			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Dead on arrival at Laurel General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last EDWIN HENRY HILLEBRAND				4. DATE OF DEATH Month Day Year August 22 1961			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 28 June 1897	9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Motel Clerk		10b. KIND OF BUSINESS OR INDUSTRY Motel		11. BIRTHPLACE (County & State, or foreign country) Blue Mound, Illinois		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME unknown				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no		16. SOCIAL SECURITY NO. 501 07 5568		17. INFORMANT Address Mrs. Edna P. Hillebrand Laurel, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Ulcer, duodenum, with repeated hemorrhage; oesophagus, renal						INTERVAL BETWEEN ONSET AND DEATH unknown	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Laurel		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1 January, 1961 to 22 August, 1961 , that (I) (we) last saw the deceased alive on July 22, 1961 , and that death occurred at 10 P , from the causes and on the date stated above.							
22a. SIGNATURE J. Richard Compton M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 22 August 1961	
22c. PHYSICIAN'S NAME (Type) J. Richard Compton, M. D.				22d. ADDRESS 612 Main Street, Laurel, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF August 26, 1961	23c. NAME OF CEMETERY OR CREMATORY Michigan Cemetery		23d. LOCATION (City, town or county) Michigan, North Dakota			
24. FUNERAL DIRECTOR'S SIGNATURE De Witt Donaldson				25. REC'D BY REGISTRAR AUG 25 61		25b. REGISTRAR'S SIGNATURE Arthur S. Hall	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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United States
Department of
Health and
Human Services

Office of
Public Health
and Safety

Washington, D.C.

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Department of Health and Human Services

Office of Public Health and Safety

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be furnished by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9214

09204

1. PLACE OF DEATH a. COUNTY Howard b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Savage Md c. LENGTH OF STAY IN 1b 2 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Guilford Road				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Maryland b. COUNTY Howard c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Savage Md d. STREET ADDRESS Guilford Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First George Middle Loy Last Ickes				4. DATE OF DEATH Month August Day 15 , Year 19 61											
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb 22, 1882		9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Machinist				10b. KIND OF BUSINESS OR INDUSTRY U S Government				11. BIRTHPLACE (County & State, or foreign country) Pennsylvania				12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) yes WW I				16. SOCIAL SECURITY NO. WW I				17. INFORMANT Georgana Plotts Riverdale, Md. Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer Throat 148X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Canker sores of mouth (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH 4 mo 6 yrs.															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 2/10 19 61 , to 8/15 19 61 , that (I) (we) last saw the deceased alive on 8/14 19 61 , and that death occurred at 5:30 AM on the causes and on the date stated above.															
22a. SIGNATURE B. Warner M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 8/12/61							
22c. PHYSICIAN'S NAME (Type) Laurel						22d. ADDRESS Md									
23a. BURIAL, CREMATION, or other disposal (Specify) Burial				23b. DATE THEREOF Aug 17, 1961		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery				23d. LOCATION (City, town or county) (State) Colmar Manor, Md.					
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons						ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR AUG 18 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kline					

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CERTIFICATE OF DEATH

Reg. Dist. No. 09205

9215

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 8			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shaffers Convalescent Retreat				d. STREET ADDRESS 620 Stevenson Road 03X-2			
3. NAME OF DECEASED (Type or print) First WALTER Middle SAWIN Last				4. DATE OF DEATH Month August Day 15 Year 19 61			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 27, 1877	9. AGE (In years lost birthday) yrs. 83	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Sudbury Mass		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Miriam Sawin				14. MOTHER'S MAIDEN NAME Sarah L. Brown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 021-18-5073		INFORMANT Address Willard Linfield, 620 Stevenson Lane, Balto. Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)						INTERVAL BETWEEN ONSET AND DEATH Instant	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1, 1961 to Aug. 15, 1961 , that I last saw the deceased alive on Aug. 14, 1961 , and that death occurred at 1:15 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Charles S. Whitaker		M.D.		ADDRESS (Street, city or town, state) C/Arksville, Md		DATE SIGNED 8/15/61	
PHYSICIAN'S NAME (Type) CHARLES S. WHITAKER, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-18-61		22c. NAME OF CEMETERY OR CREMATORY Mt. Pleasant		22d. LOCATION (City, town, or county) (State) Sudbury, Mass	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md				24a. REC'D BY REGISTRAR AUG 17 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
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THE UNIVERSITY OF CHICAGO

CHICAGO, ILL.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
09206									
1. PLACE OF DEATH a. COUNTY Howard					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Ellicott City					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington D.C. 18				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Ellicott Road					d. STREET ADDRESS 1002 Rhode Island Ave. N.E.				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) ELLEN THOMAS					4. DATE OF DEATH Month Day Year August 22 1961				
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 26, 1866		9. AGE (In years last birthday) 95 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Richmond Va		12. CITIZEN OF WHAT COUNTRY? Unknown			
13. FATHER'S NAME Samuel Anderson					14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (Yes, no, or unknown)					16. SOCIAL SECURITY NO. (If yes, give number or date of service)				
17. INFORMANT Alberta Wilson, Ellicott Rd. Ellicott City, Md					Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) 420.1 DUE TO (e), stating the underlying cause last. (c)									
INTERVAL BETWEEN ONSET AND DEATH Instant									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Charles S. Whitaker, M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) Charles S. Whitaker					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
DATE SIGNED 8-22-61									
22a. BURIAL, CREMATION, REMOVAL (Specify) 8-25-61					22b. DATE THEREOF 8-26-61				
22c. NAME OF CEMETERY OR CREMATORY Carver Memorial					22d. LOCATION (City, town, or country) (State) Maryland Laurel				
23. FUNERAL DIRECTOR D.R. Cameron					24a. REC'D BY REGISTRAR 611-K St. N.W.				
24b. REGISTRAR'S SIGNATURE DATE 8-29-61									



1. 1. 1.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

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09207

1. PLACE OF DEATH a. COUNTY <i>Howard</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Howard</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural. Sykesville</i>				c. LENGTH OF STAY IN 1b <i>Life</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>FANNIE</i> Middle <i>THOMPSON</i> Last <i>WEST</i>				4. DATE OF DEATH Month <i>Aug.</i> Day <i>1</i> Year <i>1961</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Col.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 12, 1878</i>	9. AGE (In years last birthday) <i>82</i> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John Thomas</i>				14. MOTHER'S MAIDEN NAME <i>Unknown</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>Geo Thompson - Sykesville, Md.</i> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis, right hemisphere</i> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cardiac failure, arteriosclerosis</i> DUE TO (c) <i>Generalized Arteriosclerosis H.D.</i>						INTERVAL BETWEEN ONSET AND DEATH <i>1960</i> <i>1 Aug 61</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>1960</i> 19 to <i>1 Aug</i> 19 <i>61</i> , that (I) (we) last saw the deceased alive on <i>1 Aug</i> 19 <i>61</i> , and that death occurred at <i>3:30 PM</i> , from the causes and on the date stated above.							
22a. SIGNATURE <i>Howard E. Hawo</i> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>2 Aug 61</i>	
22c. PHYSICIAN'S NAME (Type) <i>HOWARD E. HAWO</i>				22d. ADDRESS <i>SYKESVILLE, MD.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>8-4-61</i>		23c. NAME OF CEMETERY OR CREMATORY <i>White Rock</i>		23d. LOCATION (City, town, or county) (State) <i>Sykesville, Carroll Co., Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur L. Haight</i> ADDRESS <i>Sykesville, Md.</i>				25a. REC'D BY REGISTRAR DATE <i>AUG 7 '61</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur L. Haight</i>	

(M)

(I)

RECEIVED

1911

M

TO THE HONORABLE
THE SECRETARY OF THE
NAVY
WASHINGTON, D. C.

DEAR SIR:

I have the honor to acknowledge the receipt of your letter of the 14th inst. in relation to the above subject. The same has been forwarded to the proper authorities for their consideration. I am, Sir, very respectfully,
Yours very truly,
J. D. [Signature]